NATIONAL PROVIDER ENROLLMENT CONFERENCE

57 Million Patients, 2 Million Providers, ONE Mission

855A Enrollment & Policy Overview

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Session Overview

- Who should complete the CMS-855A?
- Overview of the CMS-855A application and the PECOS equivalent
- Explore the benefits of PECOS vs paper-based application
- Discuss Part A enrollment policies and procedures

What is the 855A?

- The Medicare Enrollment Application for Institutional Providers.
- This form is also used to submit changes to your enrollment data.

855A Initial Enrollment Process

Provider Actions:

- Contact state agency for certification forms
- Complete CMS-855A and submit it to the MAC serving your state

*** Must be in compliance at time of survey (operational & providing services to patients)*

MAC Actions:

- Screen and validate
- Submit recommendation of approval to State agency, copy to CMS RO

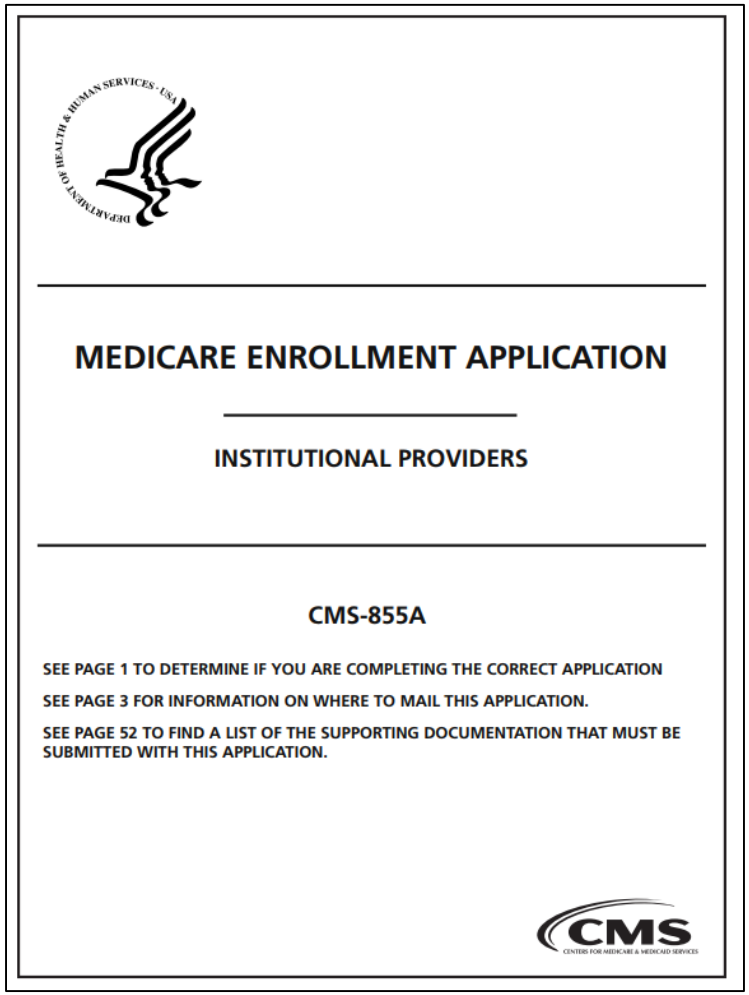
MAC Actions:

- Processes tie-in
- Updates PECOS and claims systems

CMS RO/ State Survey Agency Actions:

- On-site certification survey
- If COPs are met, RO issues provider agreement and assigns provider number

Getting Started – The CMS-855A Application



MEDICARE ENROLLMENT APPLICATION

INSTITUTIONAL PROVIDERS

CMS-855A

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 52 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

You can find the paper application at the following link:

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf

Section 1A – Basic Information – Reason for Application

SECTION 1: BASIC INFORMATION *(Continued)*

A. Check one box and complete the required sections

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
☐ You are a **new enrollee** in Medicare	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable** sections except **2F, 2G,** and **2H**
☐ You are enrolling with another fee-for-service contractor's jurisdiction ☐ You are **reactivating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable** sections except **2F, 2G,** and **2H**
☐ You are **voluntarily terminating** your Medicare enrollment	Effective Date of Termination: Medicare Identification Number(s) to Terminate *(if issued)*: National Provider Identifier *(if issued)*:	**Complete sections: 1, 2B1, 13,** and either **15** or **16**
☐ There has been a **Change of Ownership (CHOW)** of the Medicare-enrolled provider You are the: ☐ Seller/Former Owner ☐ Buyer/New Owner	Tax Identification Number:	**Seller/Former Owner: 1A, 2F, 13,** and either **15** or **16** **Buyer/New Owner: Complete all** sections except **2G** and **2H**
☐ Your organization has taken part in an **Acquisition** or **Merger** You are the: ☐ Seller/Former Owner ☐ Buyer/New Owner	Medicare Identification Number of the Seller/Former Owner *(if issued)*: NPI: Tax Identification Number:	**Seller/Former Owner: 1A, 2G, 13,** and either **15** or **16** **Buyer/New Owner: 1A, 2G, 4, 13,** and either **15** (if you are the authorized official) or **16** (if you are the delegated official), and **6** for the signer if that authorized or delegated official has not been established for this provider.

Application fee for institutional providers for 2017 - $560

Section 1A – Basic Information – Reason for Application

SECTION 1: BASIC INFORMATION *(Continued)*

A. Check one box and complete the required sections

☐ Your organization has **Consolidated** with another organization You are the: ☐ Former organization ☐ New organization	Medicare Identification Number of the Seller/Former Owner *(if issued)*: NPI: Tax Identification Number:	**Former Organizations: 1A, 2H, 13,** and either **15** or **16** **New Organization: Complete all** sections except **2F** and **2G**
☐ You are **changing** your Medicare information	Medicare Identification Number *(if issued)*: NPI:	**Go to Section 1B**
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections except 2F, 2G, and 2H**

Changes must be reported within 30 or 90 days.

Revalidation every 5 years – DO NOT wait to report changes of information.

Changes of Information

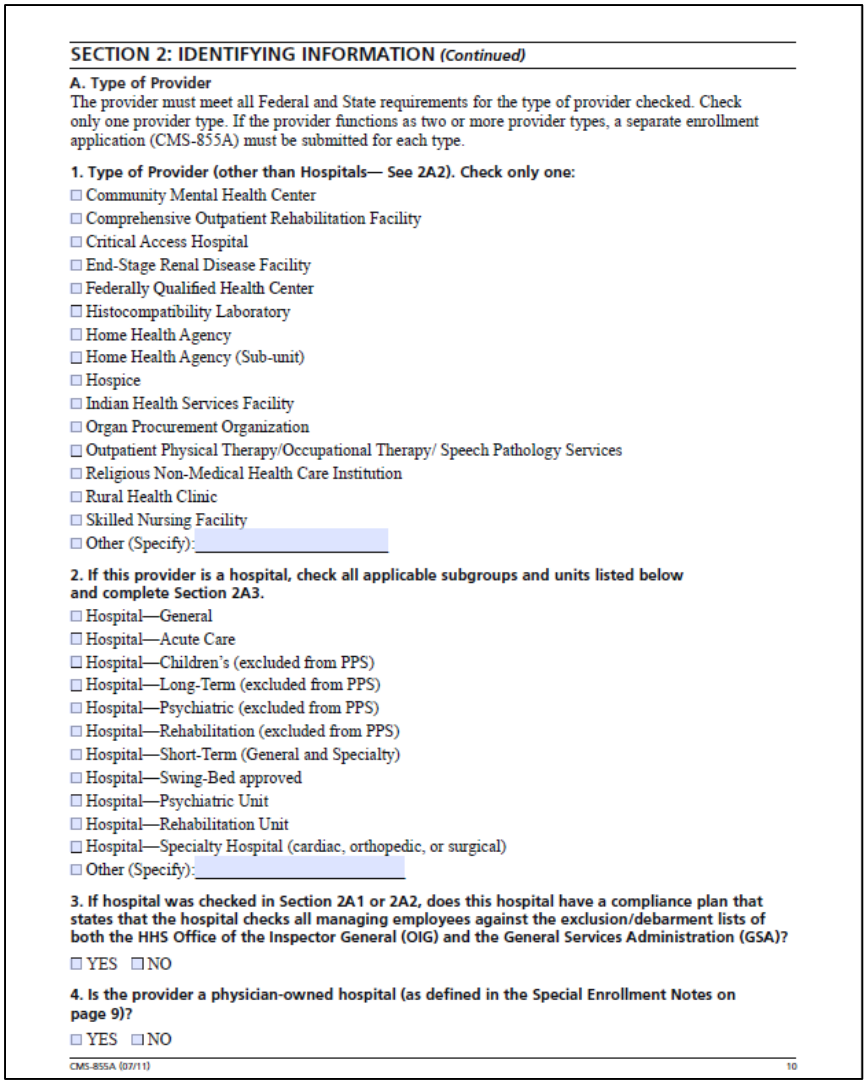
Within 30 days-

- A change in ownership
- An adverse legal action
- A change in practice location.

Within 90 days-

- Managing employees
- AO/DO
- All other changes.

Section 2 – Identifying Information



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

A. Type of Provider

The provider must meet all Federal and State requirements for the type of provider checked. Check only one provider type. If the provider functions as two or more provider types, a separate enrollment application (CMS-855A) must be submitted for each type.

1. Type of Provider (other than Hospitals— See 2A2). Check only one:

- ☐ Community Mental Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ Critical Access Hospital
- ☐ End-Stage Renal Disease Facility
- ☐ Federally Qualified Health Center
- ☐ Histocompatibility Laboratory
- ☐ Home Health Agency
- ☐ Home Health Agency (Sub-unit)
- ☐ Hospice
- ☐ Indian Health Services Facility
- ☐ Organ Procurement Organization
- ☐ Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
- ☐ Religious Non-Medical Health Care Institution
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Other (Specify):

2. If this provider is a hospital, check all applicable subgroups and units listed below and complete Section 2A3.

- ☐ Hospital—General
- ☐ Hospital—Acute Care
- ☐ Hospital—Children's (excluded from PPS)
- ☐ Hospital—Long-Term (excluded from PPS)
- ☐ Hospital—Psychiatric (excluded from PPS)
- ☐ Hospital—Rehabilitation (excluded from PPS)
- ☐ Hospital—Short-Term (General and Specialty)
- ☐ Hospital—Swing-Bed approved
- ☐ Hospital—Psychiatric Unit
- ☐ Hospital—Rehabilitation Unit
- ☐ Hospital—Specialty Hospital (cardiac, orthopedic, or surgical)
- ☐ Other (Specify):

3. If hospital was checked in Section 2A1 or 2A2, does this hospital have a compliance plan that states that the hospital checks all managing employees against the exclusion/debarment lists of both the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA)?

☐ YES ☐ NO

4. Is the provider a physician-owned hospital (as defined in the Special Enrollment Notes on page 9)?

☐ YES ☐ NO

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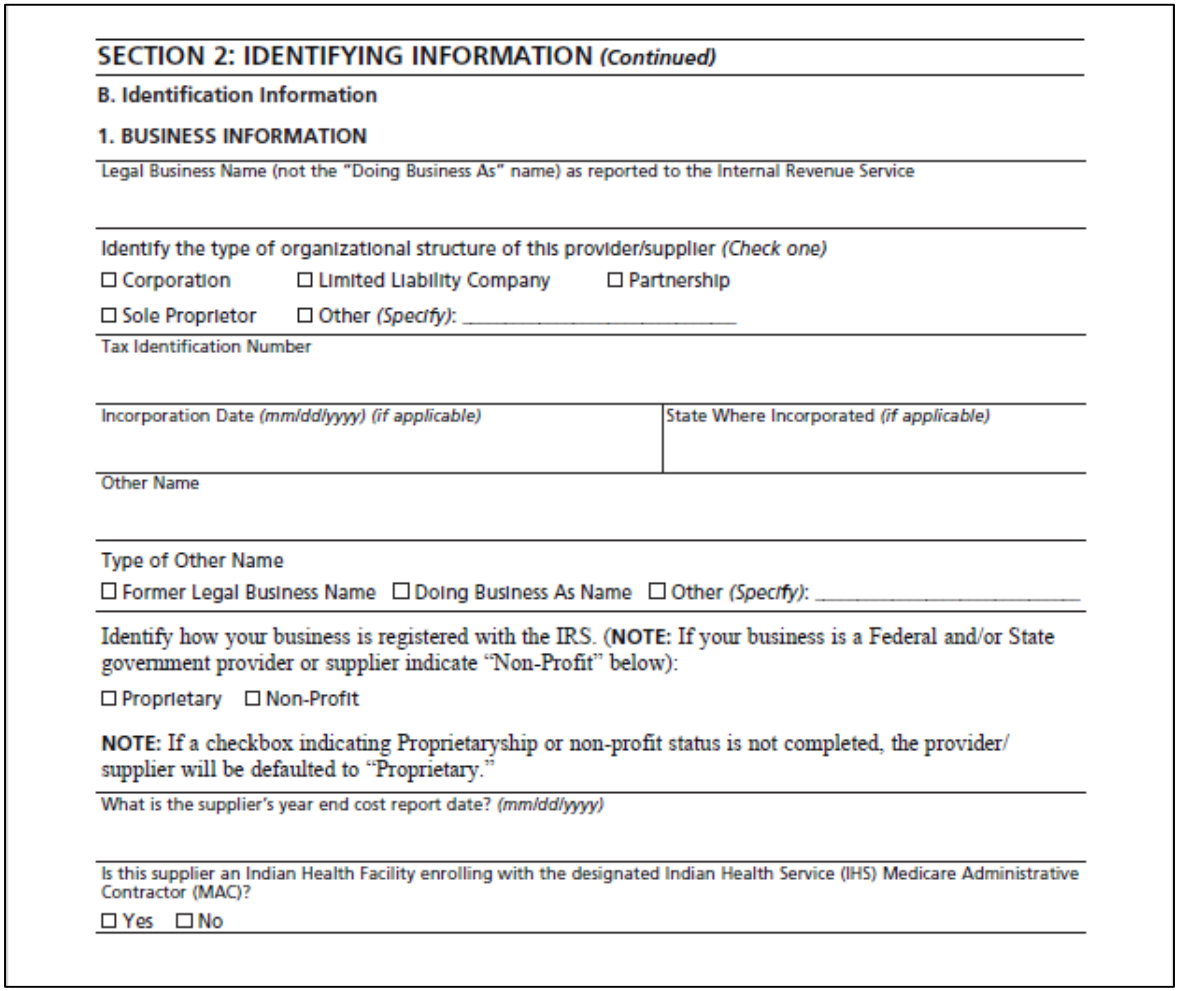
Section 2A1 – only select one provider type

Section 2A2 – Hospitals, select all subgroups and units that apply

Form CMS-855POH isn't currently in use

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Section 2 – Identifying Information



SECTION 2: IDENTIFYING INFORMATION *(Continued)*

B. Identification Information

1. BUSINESS INFORMATION

Legal Business Name (not the "Doing Business As" name) as reported to the Internal Revenue Service

Identify the type of organizational structure of this provider/supplier *(Check one)*

☐ Corporation ☐ Limited Liability Company ☐ Partnership

☐ Sole Proprietor ☐ Other *(Specify)*: _____

Tax Identification Number

Incorporation Date *(mm/dd/yyyy) (if applicable)*	State Where Incorporated *(if applicable)*

Other Name

Type of Other Name

☐ Former Legal Business Name ☐ Doing Business As Name ☐ Other *(Specify)*: _____

Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government provider or supplier indicate "Non-Profit" below):

☐ Proprietary ☐ Non-Profit

NOTE: If a checkbox indicating Proprietaryship or non-profit status is not completed, the provider/supplier will be defaulted to "Proprietary."

What is the supplier's year end cost report date? *(mm/dd/yyyy)*

Is this supplier an Indian Health Facility enrolling with the designated Indian Health Service (IHS) Medicare Administrative Contractor (MAC)?

☐ Yes ☐ No

Existing providers cost report end date must match original application.

It cannot be updated via CMS-855A

Section 2 – License/Certification Information

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the provider has a State license/certification to operate as the provider type for which you are enrolling.

☐ State License Not Applicable

License Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Certification Information

☐ Certification Not Applicable

Certification Number	State Where Issued
Effective Date *(mm/dd/yyyy)*	Expiration/Renewal Date *(mm/dd/yyyy)*

Certification does not mean Medicare certification or HRSA Grant/Award certificate.

Section 2 – Correspondence Address

C. Correspondence Address

Provide contact information for the entity listed in Section 2B1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*		
Mailing Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Contact Information is VERY important because this is where the MAC will be sending important letters and documents directly to the provider.

Section 2 – Accreditation

D. Accreditation

Is this provider accredited? ☐ YES ☐ NO

If YES, complete the following:

Date of Accreditation *(mm/dd/yyyy)*	Expiration Date of Accreditation *(mm/dd/yyyy)*

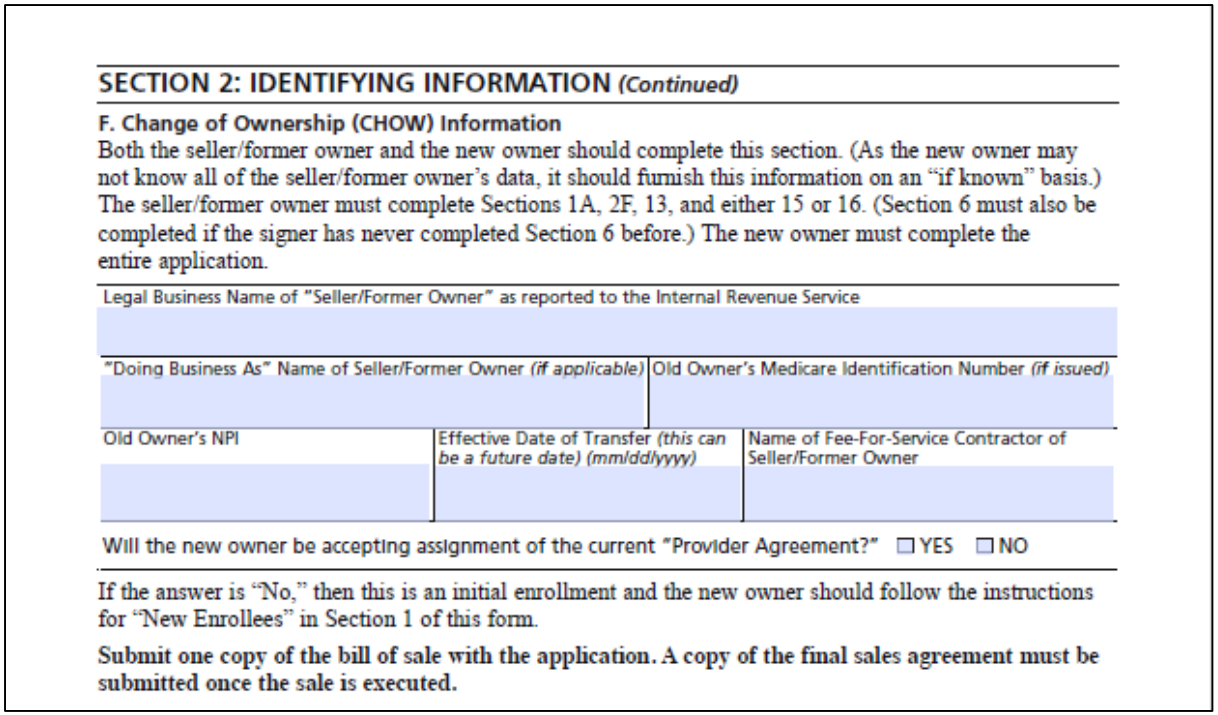
Name of Accrediting Body

Type of Accreditation or Accreditation Program (e.g., hospital accreditation program, home health accreditation, etc.)

E. Comments

Use this section to clarify any information furnished in this section.

Section 2 – Change of Ownership (CHOW) Information



SECTION 2: IDENTIFYING INFORMATION ***(Continued)***

F. Change of Ownership (CHOW) Information

Both the seller/former owner and the new owner should complete this section. (As the new owner may not know all of the seller/former owner's data, it should furnish this information on an "if known" basis.) The seller/former owner must complete Sections 1A, 2F, 13, and either 15 or 16. (Section 6 must also be completed if the signer has never completed Section 6 before.) The new owner must complete the entire application.

Legal Business Name of "Seller/Former Owner" as reported to the Internal Revenue Service		
"Doing Business As" Name of Seller/Former Owner *(if applicable)*		Old Owner's Medicare Identification Number *(if issued)*
Old Owner's NPI	Effective Date of Transfer *(this can be a future date) (mm/dd/yyyy)*	Name of Fee-For-Service Contractor of Seller/Former Owner

Will the new owner be accepting assignment of the current "Provider Agreement?" ☐ YES ☐ NO

If the answer is "No," then this is an initial enrollment and the new owner should follow the instructions for "New Enrollees" in Section 1 of this form.

Submit one copy of the bill of sale with the application. A copy of the final sales agreement must be submitted once the sale is executed.

The Effective Date of Transfer must match the effective date of the sale as noted in the sales agreement or bill of sale.

Section 2 – Acquisitions/Mergers

1. PROVIDER BEING ACQUIRED

This section is to be completed with information about the currently enrolled provider that is being acquired and will no longer retain its current Medicare provider number as a result of this acquisition.

Legal Business Name of the "Provider Being Acquired" as reported to the Internal Revenue Service
Current Fee-for-Service Contractor

Provide the name and Medicare identification number of all units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as swing bed units of a hospital and HHA branches. Also furnish the NPI. Units that already have a separate provider agreement should not be reported here.

NAME/DEPARTMENT	MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	NATIONAL PROVIDER IDENTIFIER

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SECTION 2: IDENTIFYING INFORMATION *(Continued)*

2. ACQUIRING PROVIDER

This section is to be completed with information about the organization acquiring the provider identified in Section 2G1.

Legal Business Name of the "Acquiring Provider" as Reported to the Internal Revenue Service	Medicare Identification Number (if issued)
Current Fee-for-Service Contractor	**National Provider Identifier**

Submit one copy of the bill of sale with the application. A copy of the final sales agreement must be submitted once the sale is executed.

Section 2 – Consolidations

H. Consolidations

The newly formed provider completes the entire application. The providers that are being consolidated are reported below.

1. 1ST CONSOLIDATING PROVIDER

This section is to be completed with information about the 1st currently enrolled provider that, as a result of this consolidation, will no longer retain its current Medicare Identification Number.

Legal Business Name of the "Provider Being Acquired" as reported to the Internal Revenue Service

Current Fee-for-Service Contractor

Effective Date of Consolidation

Provide the name and Medicare identification number of all units of the above provider that have separate Medicare identification numbers but have not entered into separate provider agreements, such as swing-bed units of a hospital and HHA branches. Also furnish the NPI. Units that already have a separate provider agreement should not be reported here.

NAME/DEPARTMENT	MEDICARE IDENTIFICATION NUMBER (IF ISSUED)	NATIONAL PROVIDER IDENTIFIER

Section 3 – Final Adverse Legal Actions/Convictions

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Section 3 – Final Adverse Legal Actions/Convictions

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

Section 3 – Final Adverse Legal Actions/Convictions

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against you?

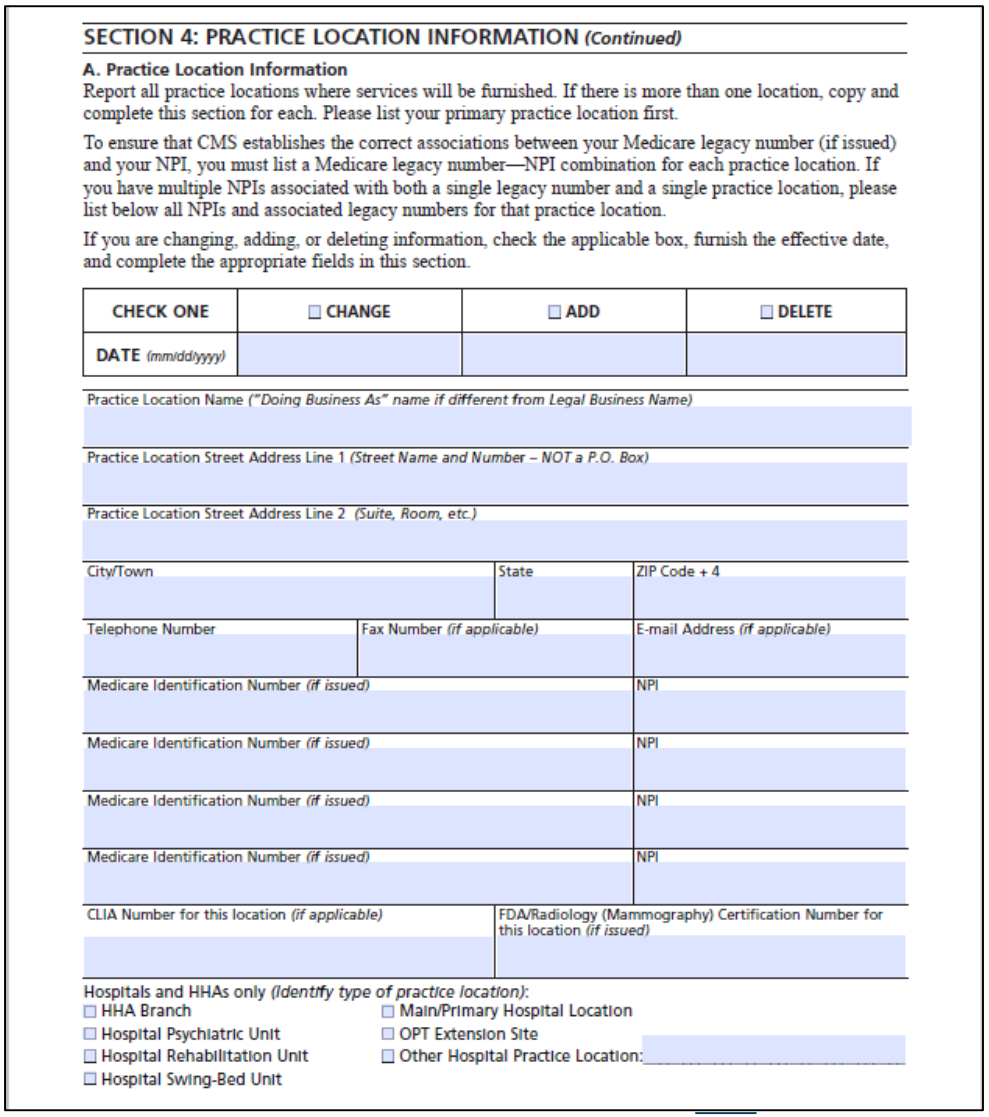
☐ YES–Continue Below ☐ NO–Skip to Section 4

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Section 4A – Practice Location Information



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. Practice Location Information

Report all practice locations where services will be furnished. If there is more than one location, copy and complete this section for each. Please list your primary practice location first.

To ensure that CMS establishes the correct associations between your Medicare legacy number (if issued) and your NPI, you must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number *(if issued)*	NPI
Medicare Identification Number *(if issued)*	NPI
Medicare Identification Number *(if issued)*	NPI
Medicare Identification Number *(if issued)*	NPI

CLIA Number for this location *(if applicable)*	FDA/Radiology (Mammography) Certification Number for this location *(if issued)*

Hospitals and HHAs only *(Identify type of practice location)*:

☐ HHA Branch
☐ Hospital Psychiatric Unit
☐ Hospital Rehabilitation Unit
☐ Hospital Swing-Bed Unit
☐ Main/Primary Hospital Location
☐ OPT Extension Site
☐ Other Hospital Practice Location: _____

Hospital with excluded units or swing-bed - enter each of the excluded units and/or swing-bed's PTAN/NPIs in Section 4 if reporting changes applicable to all.

Section 4B – Where do you want Remittance Notices/Special Payments Sent?

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

B. Where Do You Want Remittance Notices Or Special Payments Sent?
If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Medicare will issue payments via electronic funds transfer (EFT). Since payment will be made by EFT, the "Special Payments" address will indicate where all other payment information (e.g., remittance notices, special payments) are sent.

☐ "Special Payments" address is the same as the practice location (only one address is listed in Section 4A). **Skip to Section 4C.**

☐ "Special Payments" address is different than that listed in Section 4A, or multiple locations are listed. **Provide address below.**

"Special Payments" Address Line 1 *(PO Box or Street Name and Number)*

"Special Payments" Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Section 4C – Where Do You Keep Patients' Medical Records?

C. Where Do You Keep Patients' Medical Records?
If you store patients' medical records (current and/or former patients) at a location other than the location in Section 4A or 4D, complete this section with the address of the storage location.

If this section is not complete, you are indicating that all records are stored at the practice locations reported in Section 4A or 4D. The records must be the provider's records, not the records of another provider. Post Office Boxes and drop boxes are not acceptable as physical addresses where patients' records are maintained.

For mobile facilities/portable units, the patients' medical records must be under the provider's control.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

First Medical Record Storage Facility for Current and Former Patients

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

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A medical record storage facility must have a specific street address and not a PO Box.

Section 4E Base of Operations Address for Mobile or Portable Suppliers

SECTION 4: PRACTICE LOCATION INFORMATION ***(Continued)***

E. Base of Operations Address for Mobile or Portable Suppliers (Location of Business Office or Dispatcher/Scheduler)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Check here ☐ and skip to Section 4F if the "Base of Operations" address is the same as the "Practice Location" listed in Section 4A.

Street Address Line 1 *(Street Name and Number)*		
Street Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	ZIP Code + 4
Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Section 4F- Vehicle Information

F. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office) or ambulance vehicles. If more than two vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE *(van, mobile home, trailer, etc.)*	VEHICLE IDENTIFICATION NUMBER
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

If more than three vehicles are used, copy this section and complete it for each additional vehicle.

Section 4G – Geographic Location for Mobile or Portable Suppliers Base of Operations

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

G. Geographic Location for Mobile Or Portable Suppliers Where the Base of Operations and/or Vehicle Renders Services

Provide the city/town, State, and ZIP Code for all locations where mobile and/or portable services are rendered.

NOTE: If you provide mobile or portable health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855B) for each Medicare fee-for-service contractor's jurisdiction.

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE

Applicable to HHAs and mobile/portable providers to identify the geographic area(s) where health care services are rendered.

Section 5 – Ownership Interest and/or Managing Control Information – Organizations

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) ***(Continued)***

☐ Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

A. Ownership/Managing Control Organization

1. IDENTIFYING INFORMATION

Legal Business Name as Reported to the Internal Revenue Service

"Doing Business As" Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Tax Identification Number *(required)*

Medicare Identification Number(s) *(if issued)*	NPI *(if issued)*

2. TYPE OF ORGANIZATION

Check all that apply:

- ☐ Corporation
- ☐ Limited liability Company
- ☐ Medical provider/supplier
- ☐ Management services company
- ☐ Medical staffing company
- ☐ Holding company
- ☐ Investment firm
- ☐ Bank or other financial institution
- ☐ Consulting firm
- ☐ For-profit
- ☐ Non-profit
- ☐ Other *(please specify)*:

Section 5 – Ownership Interest and/or Managing Control Information (Organizations)

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

NOTE: Only report organizations in this section. Individuals must be reported in Section 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: *www.cms.hhs.gov/MedicareProviderSupEnroll*. If there is more than one organization that should be reported, copy and complete this section for each.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the supplier to furnish management services for the business.

Section 5 – Ownership Interest and/or Managing Control Information (Organizations)

C. Final Adverse Legal Action History

If reporting a change to existing information, check "Change," provide the effective date of the change, and complete the appropriate fields in this section.

☐ Change ☐ Effective Date: _____

1. Has this organization in Section 5A, under any current or former name or business identity, ever had a final adverse legal action listed on page 16 of this application imposed against it?

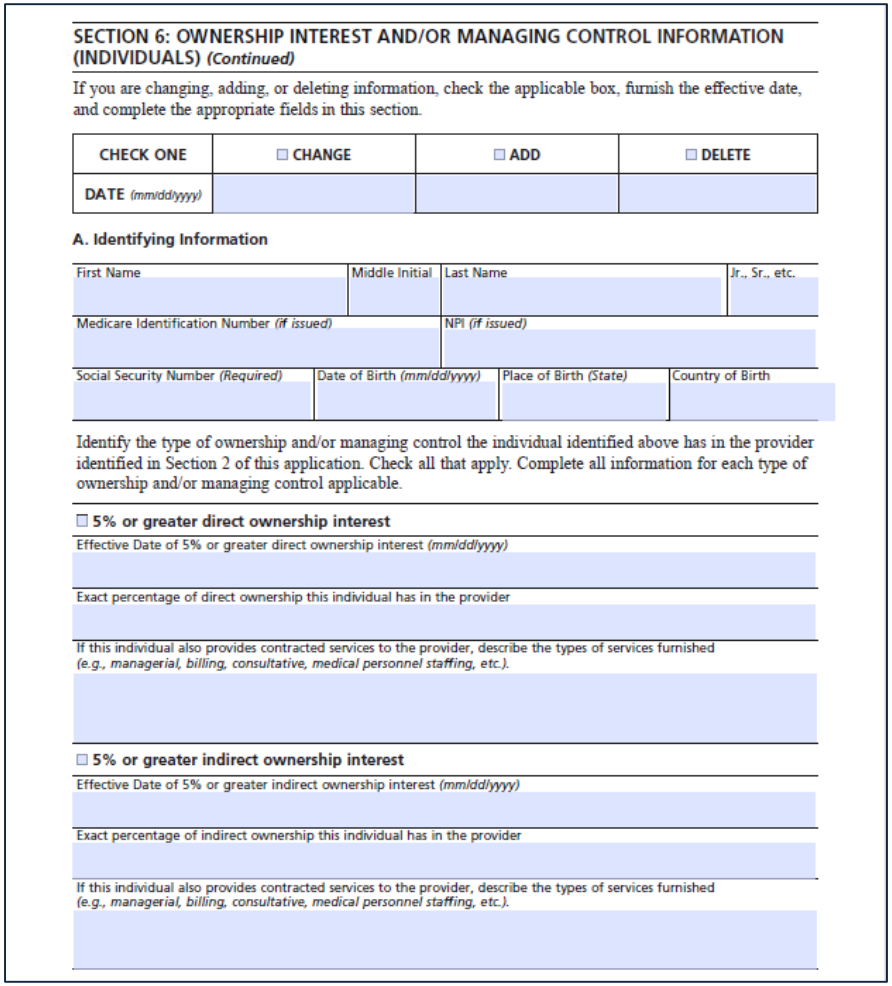
   ☐ YES–Continue Below ☐ NO–Skip to Section D

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Section 6 – Ownership Interest and/or Managing Control Information – Individuals



SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) ***(Continued)***

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

A. Identifying Information

First Name	Middle Initial	Last Name	Jr., Sr., etc.

Medicare Identification Number *(if issued)*	NPI *(if issued)*

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*	Place of Birth *(State)*	Country of Birth

Identify the type of ownership and/or managing control the individual identified above has in the provider identified in Section 2 of this application. Check all that apply. Complete all information for each type of ownership and/or managing control applicable.

☐ **5% or greater direct ownership interest**

Effective Date of 5% or greater direct ownership interest *(mm/dd/yyyy)*

Exact percentage of direct ownership this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

☐ **5% or greater indirect ownership interest**

Effective Date of 5% or greater indirect ownership interest *(mm/dd/yyyy)*

Exact percentage of indirect ownership this individual has in the provider

If this individual also provides contracted services to the provider, describe the types of services furnished *(e.g., managerial, billing, consultative, medical personnel staffing, etc.).*

Section 6 – Ownership Interest and/or Managing Control Information (Individuals)

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on "direct" and "indirect" owners, go to *www.cms.hhs.gov/MedicareProviderSupEnroll*.

The supplier MUST have at least ONE owner and/or managing employee.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier;
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials.

Section 6 – Ownership Interest and/or Managing Control Information (Individuals)

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

B. Final Adverse Legal Action History

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

☐ Change
Effective Date:_____

1. Has this individual in Section 6A above, under any current or former name or business identity, ever had a final adverse legal action listed on page 13 of this application imposed against him/her?

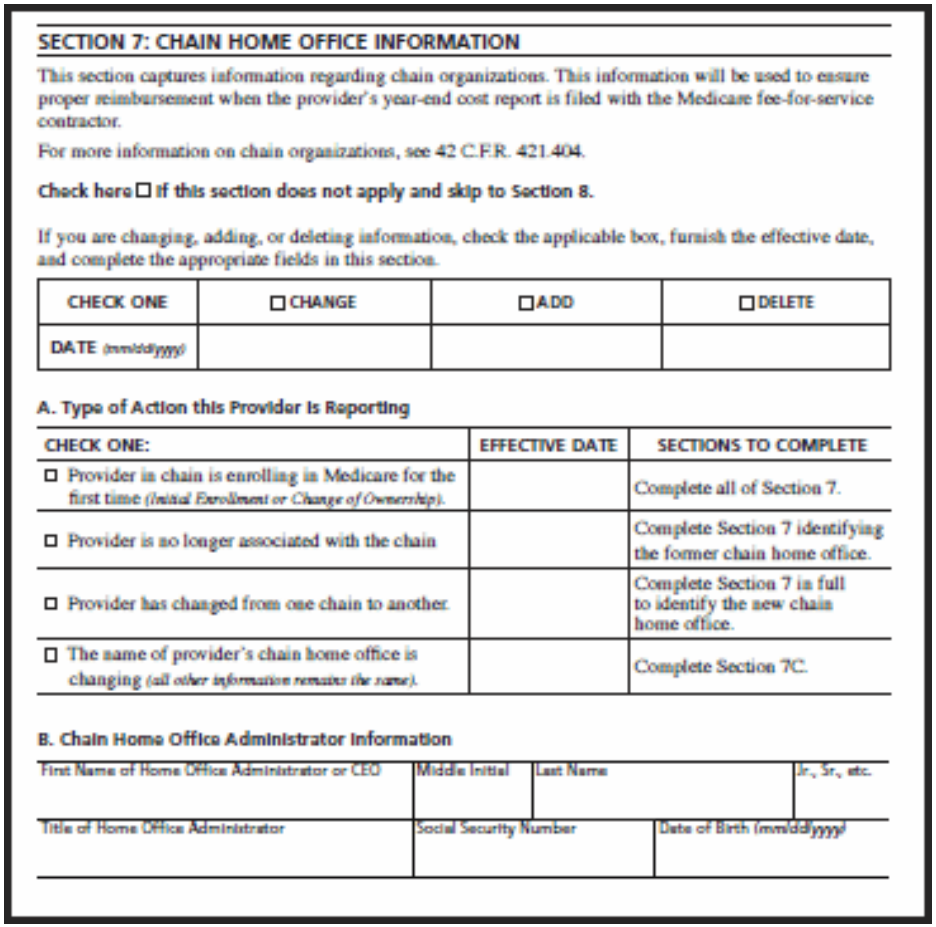
   ☐ YES–Continue Below ☐ NO–Skip to Section 8

2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

   Attach a copy of the final adverse legal action documentation and resolution.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

Section 7 – Chain Home Office Information



SECTION 7: CHAIN HOME OFFICE INFORMATION

This section captures information regarding chain organizations. This information will be used to ensure proper reimbursement when the provider's year-end cost report is filed with the Medicare fee-for-service contractor.

For more information on chain organizations, see 42 C.F.R. 421.404.

Check here ☐ if this section does not apply and skip to Section 8.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

A. Type of Action this Provider is Reporting

CHECK ONE:	EFFECTIVE DATE	SECTIONS TO COMPLETE
☐ Provider in chain is enrolling in Medicare for the first time *(Initial Enrollment or Change of Ownership)*.		Complete all of Section 7.
☐ Provider is no longer associated with the chain		Complete Section 7 identifying the former chain home office.
☐ Provider has changed from one chain to another.		Complete Section 7 in full to identify the new chain home office.
☐ The name of provider's chain home office is changing *(all other information remains the same)*.		Complete Section 7C.

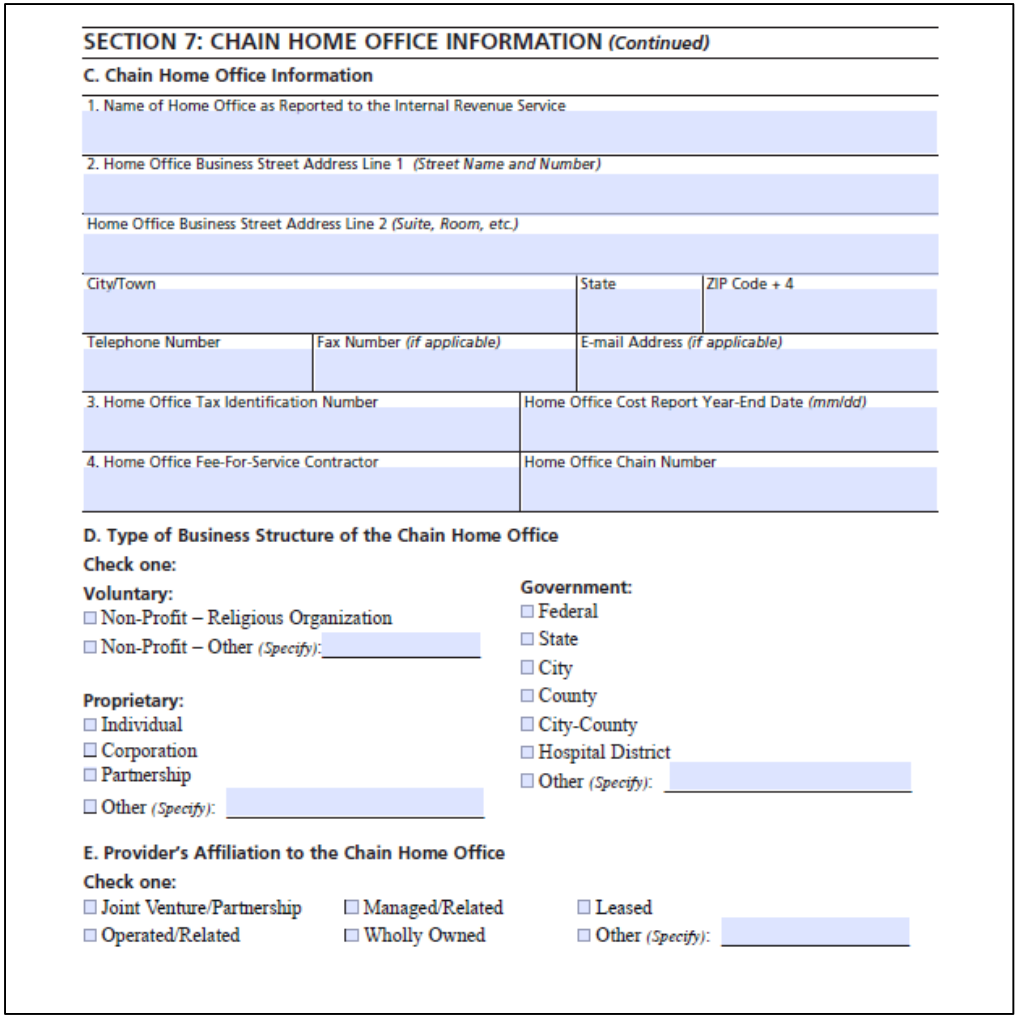
B. Chain Home Office Administrator Information

First Name of Home Office Administrator or CEO	Middle Initial	Last Name	Jr., Sr., etc.

Title of Home Office Administrator	Social Security Number	Date of Birth (mm/dd/yyyy)

This information will be used to ensure proper reimbursement when the providers year-end cost report is filed with the Medicare fee-for-service contractor.

Section 7 – Chain Home Office Information



SECTION 7: CHAIN HOME OFFICE INFORMATION *(Continued)*

C. Chain Home Office Information

1. Name of Home Office as Reported to the Internal Revenue Service

2. Home Office Business Street Address Line 1 *(Street Name and Number)*

Home Office Business Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

3. Home Office Tax Identification Number	Home Office Cost Report Year-End Date *(mm/dd)*

4. Home Office Fee-For-Service Contractor	Home Office Chain Number

D. Type of Business Structure of the Chain Home Office

Check one:

Voluntary:
- ☐ Non-Profit – Religious Organization
- ☐ Non-Profit – Other *(Specify)*:

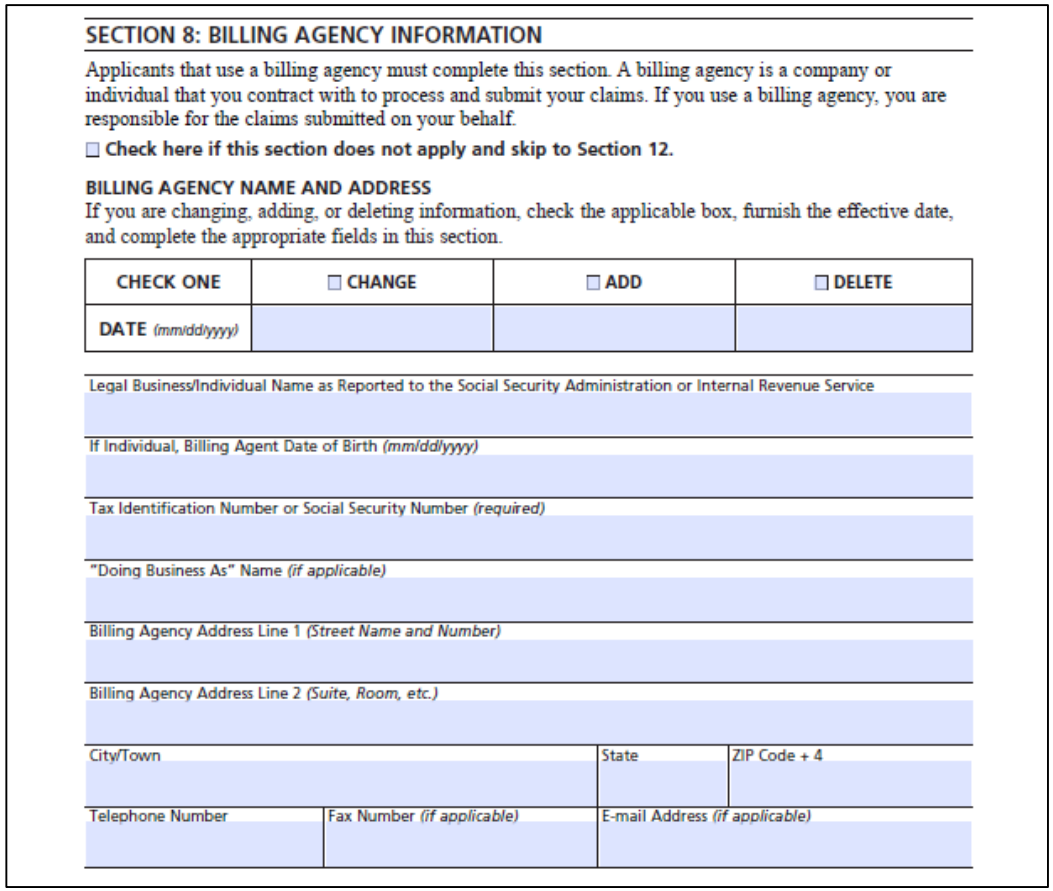
Proprietary:
- ☐ Individual
- ☐ Corporation
- ☐ Partnership
- ☐ Other *(Specify)*:

Government:
- ☐ Federal
- ☐ State
- ☐ City
- ☐ County
- ☐ City-County
- ☐ Hospital District
- ☐ Other *(Specify)*:

E. Provider's Affiliation to the Chain Home Office

Check one:
- ☐ Joint Venture/Partnership
- ☐ Operated/Related
- ☐ Managed/Related
- ☐ Wholly Owned
- ☐ Leased
- ☐ Other *(Specify)*:

Section 8 – Billing Agency Information



SECTION 8: BILLING AGENCY INFORMATION

Applicants that use a billing agency must complete this section. A billing agency is a company or individual that you contract with to process and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

☐ **Check here if this section does not apply and skip to Section 12.**

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Legal Business/Individual Name as Reported to the Social Security Administration or Internal Revenue Service

If Individual, Billing Agent Date of Birth *(mm/dd/yyyy)*

Tax Identification Number or Social Security Number *(required)*

"Doing Business As" Name *(if applicable)*

Billing Agency Address Line 1 *(Street Name and Number)*

Billing Agency Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Applicants that use a billing agency must complete this section

A billing agency is a company or individual that you contract with to prepare and submit your claims.

If you use a billing agency, you are responsible for the claims submitted on your behalf

Section 12 – Home Health Agencies

Check here ☐ if this section does not apply and skip to Section 13.

A. Type of Home Health Agency

1. CHECK ONE:

☐ Non-Profit Agency ☐ Proprietary Agency

2. PROJECTED NUMBER OF VISITS BY THIS HOME HEALTH AGENCY

How many visits does this HHA project it will make in the first:

three months of operation?_____

twelve months of operation? _____

3. FINANCIAL DOCUMENTATION

A) In order to expedite the enrollment process, the HHA may attach a copy of its most current savings, checking, or other financial statement(s) that verifies the initial reserve operating funds, accompanied by:

1) An attestation from an officer of the bank or other financial institution stating that the funds are in the account(s) and are immediately available for the HHA's use, and

2) Certification from the HHA attesting that at least 50% of the reserve operating funds are non-borrowed funds.

B) Will the HHA be submitting the above documentation with this application? ☐ YES ☐ NO

NOTE: The fee-for-service contractor may require a subsequent attestation that the funds are still available. If the fee-for-service contractor determines that the HHA requires funds in addition to those indicated on the originally submitted account statement(s), it will require verification of the additional amount as well as a new attestation statement.

HHA 36 month rule

- Occurs when an individual or organization acquires more than a 50% direct ownership interest in a home health agency (HHA) during
  1) The 36 months following the HHA's initial enrollment into the Medicare program
  2) The 36 months following the HHA's most recent change in majority ownership
- If MAC determines that a change in majority ownership has occurred within either 36-month period and no exception applies, the case is referred to CMS for approval.
- If CMS agrees with MAC's determination, the HHA's billing privileges are deactivated and the HHA must enroll as an initial applicant.

Section 13 – Contact Persons

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is an authorized or delegated official, check the appropriate box below and skip to the section indicated.

☐ Contact an Authorized Official listed in Section 15

☐ Contact a Delegated Official listed in Section 16

First Name	Middle Initial	Last Name	Jr., Sr., etc.

Telephone Number	Fax Number *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

E-mail Address

Section 14 – Penalties for Falsifying Information

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

   Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

   The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:

   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;

   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

Be sure to read this section as it outlines criminal penalties and civil liability on individuals who knowingly furnished false information.

Section 15 – Authorized Officials

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

B. 1ST Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 C.F.R. § 424.516(e).

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Telephone Number	Title/Position

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

Section 16 – Delegated Official

SECTION 16: DELEGATED OFFICIAL(S) ***(Optional)***

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the provider's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the provider to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the provider's enrollment information maintained by the Medicare program, the delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the provider and, therefore, cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to any and all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

A. 1ST Delegated Official Signature

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Delegated Official First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

☐ Check here if Delegated Official is a W-2 Employee	Telephone Number

Authorized Official Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

Resources

- ICN 903783 – Medicare Enrollment for Institutional Providers
- Medicare Provider-Supplier Enrollment website
- Medicare Program Integrity Manual – Chapter 15, section 15.16

QUESTIONS?